MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom
Ronald Reagan Building
International Trade Center
1300 Pennsylvania Avenue, N.W.
Washington, D.C.

Thursday, March 20, 2003

9:17 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
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ALICE ROSENBLATT
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DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM:
Health insurance markets for Medicare beneficiaries: work plan and preliminary analysis
-- Scott Harrison, Jill Bernstein

DR. BERNSTEIN: Good morning. Before I start I want to go through a couple of quick points. The bottom line here is that sorting out what's going on in different markets for different insurance products, or other ways of supplementing Medicare in different parts of the country for different kinds of beneficiaries with different needs and different preferences is challenging. That's what we really want to do here is to lay out some of the reasons why it seems useful for us to take a closer look at some markets, which is what we plan to do.

Secondly, I want to emphasize that the goal here today is to focus on these issues from the perspective of the beneficiaries. Sometimes the discussion is going to shift to what's going on from the perspective of plans or insurers. Those issues are clearly important. We're going to talk about them in the chapter as we develop it but we don't have time to do everything at once. I'd also mention that whereas David's presentation was billed as a 101 level, this is an AP class. We're kind of assuming that the material that we talked about in developing the chapter in the March report is still relatively fresh in your mind. If I skip over anything important or you need some background information that's not here, Scott will fill you in.

So what we want to do here is to look briefly at some interrelated aspects of market structure, quickly move through some preliminary analysis that Scott has been doing and talk about some of the issues that have come up earlier today in terms of what kind of data are out there and what you might be able to glean from them about different kinds of insurance and other supplementation, and then to talk a little bit about we plan to do in the June report and some more in-depth work we plan to do thereafter.

The first of the interrelated issues that we're trying to use to frame these concepts is the importance of the difference between individual versus group market products that are available to Medicare beneficiaries. These products can look pretty different to beneficiaries. When it comes to individual insurance beneficiaries are kind of on their own when it comes to purchasing Medigap policies or to looking at their choices among M+C options. As we've talked about in previous sessions, the M+C market was pretty volatile there for a couple years. The choices for beneficiaries who do have a choice among alternative plans can be pretty hard to sort through.

Medigap is very different. The reforms enacted in OBRA 1990, which included standardizing the policy types that can be marketed to beneficiaries reduced the level of confusion considerably and reduced the potential for abuse in the Medigap market, but it can still be a little bit complicated for beneficiaries. There are or there may be, in addition to policies I through J, high deductible options, and a Medicare Select options. But not all of these options or even all of the basic policy types are marketed in all areas. Scott will mention a little bit of that later too.

I'd also point out that once beneficiaries have made their initial choice of a Medigap plan after they reach age 65, many of them stay with that plan for a very long time. About one-fourth of beneficiaries still have the same pre-standard policy they had when the OBRA reforms were enacted in 1990.

The employer-sponsored market --

DR. REISCHAUER: Jill, is that one-quarter of the people who are still alive or one

quarter of all --

DR. BERNSTEIN: It's one-quarter of the policyholders. It's using NAIC data. Of the policies that were sold, about a quarter of them -- or that were paid for in that year, a quarter of them were prestandard, close to a quarter. There are also a large number of people who are in plans which are not open, are no longer open and haven't been open in at least three years. So it's clear that even people in standard plans, there's some evidence they don't move around a lot either.

Back to employer insurance. Employers can purchase group insurance on behalf of retirees or they can contract with M+C organizations on behalf of groups of retirees. They subsidize some portion ranging from none to all, usually most, of the policies. These contracts can include a range of benefits covering both Medicare-covered and non-covered services. In the last couple of years CMS has made some important changes to make it easier for employers to work with M+C plans to set up contracting arrangements which allow employer groups and unions to have greater flexibility in the design of the benefits packages that are negotiated with the M+C plans.

For beneficiaries, group versus individual products can look very different. The group benefits are not standardized across employers and there can be some variation in the structure of the benefits among the choices offered to employees. Most employer coverage is designed in what they call carve-out, which means that beneficiaries end up having, after Medicare pays its part they have about the same level of protection that working employees have using their employee-based insurance. That means that most of them have more comprehensive coverage than Medicare. Most have drug coverage. Most have coverage for some supplemental services such as either dental care, or eye care, vision care, things like that. But they also may have higher out-of-pocket liability at the point of service with respect to copays and deductibles and those have been increasing over the last couple of years.

The final point here is that for most retirees who have employer-based coverage there's no choice at all when it comes to the market. Choices are made for them by their employer and except for large public employers and large private sector employers most only have one or possibly two options when it comes to picking up retiree insurance. It's basically you take it or you don't.

Related to the issue of group versus individual markets, we come to the issue of federal and state regulations which applies to these policies. Medigap is subject to federal standards and most states have adopted regulations based on the model regulation that was developed by the National Association of Insurance Commissioners. However, a number of states have enacted additional law and regulation governing Medigap. Some states have extended open enrollment and community rating provisions for disabled beneficiaries under 65 who are not given these protections in federal law. Some states mandate community rating for all beneficiaries. Some have extended the open enrollment protections which may apply to all or some of the Medicare policy types.

There were two figures in your mailing materials that were put together recently by NAIC to try to summarize all these. I'd caution you, however, in looking at those data that each state does it a little bit differently. The fact that they're in one column or the other doesn't mean they're alike. Some of the them offer protections for plan A, or plan C, or plan A and C and F, and some of them for different numbers of months. You really have to look at them on a state-by-state basis to see what's actually involved.

That's actually the point here. For beneficiaries, the difference in how states regulate Medigap can affect the availability of the policies. Their regulation can also affect how much the policies cost, and there are differences in how tightly states review rate increases, and deal with market entry and exit, and deal with consumer complaints and grievances.

There are also two special provisions of Medigap I'd like to mention briefly that I hope we can deal do with more in the chapter. Those relate to the innovative benefits and Medicare Select. Both provide mechanisms for introducing additional benefits and/or greater flexibility into the existing Medigap framework. Federal statute allows insurers with the approval of state insurance regulators and the federal government to include innovative benefits not otherwise available if the benefits are cost effective and do not comprehensive the principle of standardization, which is a matter of interpretation.

These can include vendor discounts for products or services. CMS believes that this could be a vehicle for expanding choice in the Medicare market. There's currently a survey the field by NAIC which is asking states about all of the applications they've had for innovative benefits and we hope to be able to include some of the findings from that work in the June report.

Employer-based supplemental insurance is generally exempt from state regulation, at least among self-insured plans, and is governed by federal law, primarily ERISA but other things as well. Benefits, coverage, disputes, grievances, et cetera, aren't local or state issues per se here. They're employee benefit issues that might involve employers located in national headquarters hundreds or thousands of miles away.

Finally, the way that state regulation and provider organizations that bear risk or contract with organizations that do bear risk also vary significantly across states. This can affect how providers organize, or provider groups are organized, and whether insurers or health plans choose to do business in a state at all. This means that beneficiaries in different jurisdictions may be more or less likely to find a particular plan or an insurance product when they go to look for it.

Finally, the way that health insurance products are organized with respect to how they bear risk has implications for beneficiaries' exposure to risk, and also how stable their risk -- their liability is over time. In the M+C program, plans assume full risk under capitation, although as we mentioned in our last report in the new PPO demonstration there is some risk sharing between the plans and Medicare. Over the past several years M+C plans have had to increase premiums, increase cost-sharing, and cut back on additional benefits. For many beneficiaries this means that coverage appears unstable.

In the Medigap market, premiums may increase from year to year and there's considerable variation in the degree to which that happens and in the degree to which states focus their attention on rate changes. But the proportion of out-of-pocket expenses borne by beneficiaries for covered services is fixed for each policy type. This is something that beneficiaries appear to value highly, the fact that when they go to the doctor or go to the hospital they're not going to have to pay out-of-pocket. Of course, this doesn't deal with the significant proportion of health care costs that are not covered by Medicare for which the beneficiary is entirely at risk.

Employer-sponsored plans involve very different -- there's a lot of variation in the cost-sharing arrangement between employers and the plans, and considerable cost-sharing on the part of the beneficiaries. Under ERISA, employers can make significant changes to benefits as long as they have reserved the right to do so, which most of them have done, and as long as it's okay to do so given their contractual relationships with employee groups. There have in fact been significant reductions in coverage and increases in cost-sharing in retirement plans over the last

few years, and these are projected to increase in scope over time. If these plans decrease in value some beneficiaries may decide that other products, including Medicare managed care or Medicare Select or PPOs or whatever actually provide better deals for them.

The bottom line is this, what's out there for beneficiaries involves a variety of products that has evolved in different markets but which interact with each other. Some beneficiaries have no real choice when it comes to supplementation. Some do, and their needs are made complicated because of their trade-offs in the way these different kinds of products are structured. As policymakers contemplate different approaches to Medicare reform, we think it would be useful to take a look at where people have ended up in the current ecosystem of insurance markets, and to look at how different federal policies and state policies, as well as market factors, have affected beneficiary choices which Scott is going to walk you through.

DR. HARRISON: In this section we are making a small first step in looking at the diversity in markets in terms of the coverages that are held by Medicare beneficiaries by state. We believe that in most cases states contain more than one distinct insurance market, but some of the important features of the markets are determined at the state level such as Medicaid and insurance regulation.

Next time we will look at some metropolitan area data as well as demographic and other market condition data. Nonetheless, we do see great variation among states in the insurance choices made by beneficiaries.

Most of the data used in this section come from the March supplemental of the 2002 current population survey, the CPS, which measures coverage during the year 2001. The survey contains insurance coverage data for over 23,000 non-institutionalized Medicare beneficiaries with at least 200 beneficiaries from every state. We would like to note here that the relatively small sample size, particularly in the less populous states, can lead to imprecision in the state estimates and we will follow up on these results with further investigation, so take some of these numbers with a grain of salt. All the states listed here are in alphabetical order except where we got dyslexic.

The CPS data show that nationally 32 percent of Medicare beneficiaries are covered by employer-sponsored supplemental health insurance. The percentage with employer-sponsored coverage range among states from a low of 16 percent to a high of 47 percent. This slide shows those with the highest and lowest percentages of Medicare beneficiaries with employer-sponsored coverage. Some of those states with the highest levels of employer-sponsored coverage are those states that we view as having highly unionized workforces. Hawaii has an employer mandate for worker coverage whose affect may transfer to higher retiree coverage as well. Those states with relatively low levels of employer-sponsored coverage include sparsely populated rural states.

The CPS data show that overall 14 percent of Medicare beneficiaries also have Medicaid coverage. At a state level, Medicaid covered between 5 and 28 percent of Medicare beneficiaries. This slide shows states with the highest and lowest proportion of Medicare beneficiaries who receive coverage from the Medicaid program. Many southern states have a high proportion of Medicaid enrollees, but some other states do as well. States with a low proportion of dual eligible enrollees include several Midwestern states.

The CPS data show that 28 percent of Medicare beneficiaries across the country have Medigap supplemental coverage. That figure is corroborated by data that we have from the NAIC. At the state, however, there are sometimes large differences between the two data

sources. Both data sources show that there is a large variation at the state level with coverage percentages ranging from single digits to over 60 percent. This slide shows states with relatively high and low percentages of beneficiaries covered by Medigap plans based on the CPS data, and there are asterisks on the states where the NAIC data differs considerably. The states with the highest levels of Medigap coverage are all states in the north central part of the country that are largely rural. These states also tend to have relatively low level of employer-sponsored supplemental coverage.

Now for this slide we have switched to use the NAIC data. Here we find that Medigap policies which include a prescription drug benefit, plans Hi, I, and J, constitute about 8 percent of all Medigap policies sold across the country. I should say of all standard Medigap policies. It throws out the pre-standard ones.

NAIC data show that there is considerable state variation in this measure with policies H, I, and J accounting for as much as 27 percent of all standard Medigap policies, down to 1 percent in several states. I should note that in some of those states there's really only one insurer selling any drug policies.

Some of those states with the highest percentages of beneficiaries in Medigap have some of the lowest proportions of them with drug plans. We'll have to figure out if there's something going on there. Similarly, a couple of states on the list having the highest proportion of drug plans have lower rates of Medigap coverage.

Many beneficiaries also supplement Medicare by choosing a Medicare managed care plan. Unfortunately, the CPS did not ask beneficiaries whether they were enrolled in a Medicare managed care plan and therefore I used CMS administrative data to see what percentage of each state's beneficiaries were enrolled in managed care plans.

In 2001 we took the -- we have newer data but we wanted to be consistent with what we were using -- 15 percent of Medicare beneficiaries were enrolled in either M+C plans or Medicare-based cost HMOs. Medicare managed care penetration ranged from zero to over 40 percent among states. The nine states named on the low end of this slide had less than 1 percent of their Medicare beneficiaries enrolled in Medicare managed care plans. Some of those states did not have a plan offered to their residents. The states at the high end all had at least a quarter of their beneficiaries enrolled in Medicare managed care plans.

After incorporating all currently available data we applied several methods using different data from the available sources to identify which states have a disproportionately high share of beneficiaries without coverage other than traditional Medicare. We found that Arkansas, D.C., Georgia, and West Virginia to be most likely to have the highest percentage of beneficiaries without any supplemental coverage. Three of the four states were on our list of states with low Medigap coverage and the other, Arkansas, was on our list for low employer-sponsored coverage. We intend to investigate these states further and we would expect to have at least one or two of them on our list of study markets, and Jill will discuss the study markets in just a moment.

Although there were some states that had less coverage overall, we did a few simple regressions and found that, perhaps not surprisingly, that in general there is a substitution between employer-sponsored coverage and Medigap coverage, and also between Medicaid and Medigap coverage. We did find that there wasn't a significant trade-off between Medigap and Medicare managed care penetration and we'll look into that further. We are aware of other studies that have found some relationship so we will do further analysis. We hope to do some

multivariate analysis and get back to you next month on that.

Jill will now tell you more about our plans.

DR. BERNSTEIN: We divided this up into a two-stage process. For the June chapter what we hope to do is to flesh out the descriptive analysis that we started here. What we want to do is to see if we can identify patterns of coverage, relate them to some of the structural characteristics of particular states or MSAs or market areas, do some multivariate work to try to sort those out, and the ultimate goal is to come up with some examples of markets which illustrate particular patterns of coverage, areas where this -- why are their areas where there is a lot of drug policies being sold and the Medigap market seems to be flourishing compared to markets which are still dominated by employer-based insurance? And what are the implications of those different types of markets for different kinds of beneficiaries? Who has coverage? Who doesn't have coverage? How are the markets played up?

So the goal is to work through the patterns of the markets to look at some local factors, to do some additional multivariate analysis, to do some demographic analysis, and to end up with a set of four or five prototypical markets that we'd like to look at in greater detail to flesh out some of the questions that we raised earlier about how these different things work.

The next phase is to actually go out and see those places. Basically to turn off the computer and to open the window and go out and talk to people on the ground level, to talk to employers and to insurers and to local experts on health policy and planning, and consumers, and consumer advocates in some markets where there may be heavy concentrations of retirees from the federal government or VA facilities that are dominant in the local market, to talk to them about their view about what's going on the ground in those communities. And also to spend some time pretending to be consumers, which we all will be soon, getting on the Internet, calling consumer advise lines, et cetera, trying to find out what it looks like from their perspective in terms of the options that are available to them.

Then to bring all that information to bear on some questions about how some of the factors which affect the growth of these markets, like state regulation, like rules about entry and exit, like rules about community rating, or how premiums are handled, or guaranteed issue, or whatever have affected the development of different kinds of products, which now apply differentially to different kinds of insurance that are out there and then maybe be able to bring all of that to bear on some analysis of what would happen under different kinds of scenarios. We're trying to build markets that work better for getting different kinds of insurance products to beneficiaries over the long haul.

We'd really like questions or suggestions for where this ought to go.

MS. ROSENBLATT: I thought this was an excellent start. It's a very interesting topic. I have in the past been a critic on the tone used in connection with Medicare supp and I want to compliment you both on the tone. It so far is excellent and hopefully that will continue into the June report.

I do have one suggestion and, Jill, as you mentioned, you have to be real careful when you read something about regulation because it's very different. I was thinking as I was reading the stuff about the state regulation that maybe a ranking of regulation from the most extreme form of regulation which I would consider to be preapproval of rates to the lesser form, so maybe a high, medium, low type of regulation versus what is available in the marketplace would be something interesting to look at.

DR. REISCHAUER: I always knew that the Medicare supplemental market was a

confusing one and now I'm confused even more. In your description of Medigap you say that a quarter of the folks in Medigap are in group plans and group plans usually purchased by employers or unions but sometimes by associations like AARP. Then I'm going to the CPS information and I'm asking myself, where are there? Are they in the employer-sponsored category or are they not?

DR. HARRISON: It's even worse than you fear because --

DR. REISCHAUER: I'm sorry I asked the question then.

DR. HARRISON: When you look at the NAIC data in some states AARP is a group and in some states it's an individual.

DR. REISCHAUER: But I'm thinking about the CPS data.

DR. HARRISON: The CPS data is supposed to be -- it's usually not that the employer buys you a Medigap policy. It's that they might help you pay for it. So it would still be considered Medigap if you're buying a Medigap policy.

DR. REISCHAUER: So the employer doesn't contract with a Medigap provider?

DR. HARRISON: They might do that but then I think they're typically not going to give you the standard package. I think that they're going to coordinate more with their other retirees and non-Medicare eligibles. It could be that maybe --

DR. REISCHAUER: But where does it go in the CPS?

DR. HARRISON: I could go into both.

DR. REISCHAUER: That's reassuring.

DR. HARRISON: The CPS categories we have now are not mutually exclusive. But the total for Medigap looks similar to the total we get from NAIC. So we are assuming --

DR. REISCHAUER: Which includes the group.

DR. HARRISON: -- that's what Medigap is, it's the individually purchased.

DR. WAKEFIELD: Just out of curiosity, do we have any idea about how many Medicare beneficiaries qualify, are dual eligibles and so qualify and are enrolled in both Medicaid and Medicare versus -- benefiting from both of those programs, versus those who may be eligible but are not enrolled? Do you have any sense of what that looks like?

DR. BERNSTEIN: There's some discussion of in the March report chapter. It varies by state to state. Nobody believes any estimate that's ever made of -- of how many people who are dual eligibles are not enrolled. There's been some research on it. We know there's a lot of people in every state who are eligible for Medicaid who do not sign up for it. That also varies from state to state because of the way that states do outreach, or for a lot of other reasons.

We've looked at the CPS estimates versus other data sources on the number of dual eligibles in the states and there is variation. Everybody who's ever done this has found some, but ours are generally -- they're generally consistent. We have a sense. None of the numbers are particularly ones that you'd want to take home with you and memorize.

DR. WAKEFIELD: Two other follow-up to that, if I could. You mentioned that you're going to be, in your case studies probably doing interviews with FEHBP and VA administrators. I know this is a stretch, but if you happen to choose any state that also has a Native American population at least I for one would be interested in a little bit of a take there. We're getting a lot of -- there are a lot of discussions now with the aging of that population that historically, while there's variation across the country, historically that was a population the longevity of which was not very favorable. However, they're aging out too now in the aggregate, and there's some interesting dynamics going on between IHS, and then as soon as folks become eligible for

Medicare and what they have access to there. So just if you happen to be in that area, if you'd keep an eye out for it.

Then last point. I don't want to sound parochial -- first time ever, I'm sure -- the North Dakota data -- I hate to even mention the state -- you've got this listed on the chart in terms of Medigap, prescription drug coverage. You've got the category of states that have the most participation, 1 to 3 percent with those prescription drug benefit policies. I didn't think we have any of those three in North Dakota frankly.

DR. HARRISON: We can check the data, but it could be actually that you used to have them and people -- you can never kick people out. Medigap policies are guaranteed renew. So it could be that these are all old policies.

DR. WAKEFIELD: There's still alive and well.

DR. HARRISON: But I thought I found current -- I went and looked and I thought I found at least one drug plan in every state.

DR. WAKEFIELD: I think not. Let's just say, will you double-check that?

DR. HARRISON: Yes.

DR. WAKEFIELD: Because, frankly, I made a call on this yesterday because I thought even over the last number of years that we haven't had any of these three plans, and at least I told state yesterday --

DR. HARRISON: Have you checked with AARP? I don't know if it's them but --

DR. WAKEFIELD: No, I haven't checked with AARP so maybe that's it.

DR. ROWE: I think this is very interesting and I agree with Alice about the level playing field that's been established here in terms of language. Just a couple suggestions.

One is, I think it's going to be very helpful to show some information over time because there's been these dramatic changes in the availability of retiree benefits through many corporations, and people not familiar with that should see that, and changes in Medigap over time. I think that it might be very helpful to show some changes over time also in premiums, which in Medigap are rising substantially.

I think it would be helpful to, rather than just indicate what percent of people have retiree benefits from employers versus Medigap versus whatever, to make sure it's clear what the differences are in the structure of the programs. For instance, Medigap has first dollar coverage. It really doesn't give any incentive for that much cost-sharing or a reduction in utilization. Whereas many of the employer-based programs have a lot of copayments, a high deductible, they may have an HRA arrangement, whatever, that gives much more incentive to reduce expenditures.

So rather than just Medigap versus -- it's not like you're getting the same thing from Medigap that you're getting from your corporation. There are differences in the structure of these things and I think that that influences who takes them and who doesn't, and the kinds of performance. So that would be a helpful thing to describe.

You said that you didn't see a trade-off between Medigap and M+C, and I thought that was interesting, and you sounded like you thought it was interesting also. I think the analysis I would do is with the Medigap H, I, J versus M+C, because it's the M+C that has the pharmaceutical benefits. So it's really the H, I, J that has the pharmaceutical benefits and that's where you might see a relationship. So I would look at it that way.

A word about the PPOs, just because they're there and they should be mentioned. It's not a big part of the program but certainly it's there and it's something that CMS seems to be talking

about more and more.

And the last comment was about the states. I don't think I understand fully why we're having such a state-oriented discussion today. I know that's the way Congress is elected and all that, but it seems to me that it's not that informative. It doesn't go that much beyond showing that there is variation. There are 50 states and some are higher and some are lower in these things, and it's kind of obvious why that is, as you point out, because of where certain employers are, et cetera. It just seems to me that it's just going to create some problems because people are going to say, my state doesn't have this sort, or it does have that, or you've got it wrong, or it's unfair, and it really doesn't inform the discussion that much.

But if you're going to do it, and then you said you might do some MSAs and other things, I would suggest that you consider the possibility of looking at the 10 CMS regions, because some of the proposals that are being discussed about Medicare reform seem to be based on consideration of larger units of analysis than county and seem to be based on these 10 CMS regions. So to whatever extent this kind of analysis is coming at the same time that other proposals are being discussed in Congress or elsewhere, in addition to states and MSA regions or rural regions, whatever you're going to do, those 10 CMS regions might be informative.

DR. HARRISON: We started with states because we wanted to get a clue as to what markets to look at. Some of the data we really only have by state. Medigap stuff really is only by state. So what we're trying to do is get clues as to which markets to really go into for our study markets.

DR. MILLER: Just to say that differently, it's correct, we're not headed towards doing this analysis by state. We're headed towards doing this analysis in selected areas that we think represent a typology of markets, then we can look at how this market develops, look at how this one, does it inform how you might want to enter a given market.

The state stuff was really, I think, intended at this preliminary stage to illustrate stuff that we might be looking at. Is that fair, Scott?

DR. HARRISON: Yes.

MR. HACKBARTH: I just want to second Jack's point about looking at trends over time. One of the issues here, of course, is that it's in a state of flux and the trends are not good trends in terms of availability of coverage. As I recall, our June report from last year on the Medicare benefit package actually had quite a bit of information about what was happening to employer-sponsored coverage and availability of Medigap. I think reiterating that is worthwhile.

DR. REISCHAUER: Just to comment on Jack's point and defend a bit looking at this by state, Medigap is, to a certain extent, regulated and licensed by states, number one. And number two, Medicaid most certainly varies by state. So while I appreciate that there's -- because I plop you down as a random person in the state of New Jersey, that doesn't increase the probability that you'll have employer-sponsored supplemental insurance. What matters it whether you worked for Bell Labs or not.

MS. ROSENBLATT: I was going to make that point as well because I think the regulatory environment is a key variable that I'm hoping we look at. But there's another variable that may or may not be able to explain some of the state variation and that may be, does one health plan have a leading market share? I'm thinking, some of the states where the Blue plan has a lot of market share may absolutely dominate the Med supp market either because they want to or because they're forced to. So that might be something to look at.

MR. SMITH: On Jack's point about trends over time, I think it's important. Just a

caution, particularly on the employer-sponsored stuff, Jack. We're going to see a surge in the number of Medicare beneficiaries with employer insurance, which is misleading. The number of working people who will eventually have employer-provided insurance is going to sharply decline. But in the next decade, the number of Medicare beneficiaries with employer-supplemented insurance is going to soar because of the pattern of retirement, particularly in the public sector.

DR. ROWE: I think that's a good point. I think there are too -- if I can respond to that. There are two different graphs one can envision, or a discussion. One is the number of companies that are offering retiree benefits, and that will go down from 60 percent-plus a couple decades ago to 30 or slightly less than that now. You could even characterize what's offered as a strong versus a weak benefit, or a robust versus a less robust benefit and you would see even a further decline in the total value because benefits are being cut back.

The second curve is the number of people who are Medicare beneficiaries, or the proportion of Medicare beneficiaries who have access to a benefit. If you plot that over time you're going to see this secular effect that David is pointing to. Maybe doing those two things will be really helpful in terms of pointing out when the problem is going to hit and why the behavior in the market now isn't consistent with what you think is this looming crisis. I think that's the point.

MS. ROSENBLATT: On that point, I think FASB 106 started the decline in employer-sponsored coverage. Now for private employers it's probably the combination of the FASB 106 impact as well as the increase in cost. But there's now GASB, which I'm less familiar with, but in picking on David's point about the public employers, I think there's a new requirement that is similar to FASB which would probably serve to decrease that population, but I don't know when it takes effect. I just don't know the details of it.

MR. SMITH: I'm not sure about the accounting provision, but again, the phenomenon has to do -- the population of people who will be receiving employer-paid benefits and the population of people who are eligible for them are going in opposite directions. This is a residual phenomenon. Jack, the 60 percent that had employer-sponsored retirement coverage that Jack refers to a couple decades ago are now retired or retiring. And the pattern, particularly in the industrial sector and the public sector of very heavy retirements in the next decade, that population is going to bulge at the same time that the underlying market is deteriorating sharply.

MR. HACKBARTH: Okay, thank you very much.